EVERSLEY MEDICAL CENTRE

Date form completed	**CONFIDENTIAL HEALTH QUESTIONAIRE FOR NEW PATIENTS** **Children Only**	**Have you been registered with this surgery before?** **If yes, when? ……**

Please complete every section. If you do not have the information or the section does not apply to you, please write this as your answer and then move on to the next question. There is a section at the end of the form if you need to explain something concerning your health, in more detail.

Last Surname	**First name**	**Middle name**
Address	**Home** **Work** **Mobile**	

DOB	**Gender**	**Male**		**Female**	

City and country of birth_____	If you born overseas, when did you move to England Month …….. Year ……

Is this child a carer? If yes, who do they care for	**Name**	**Relationship to child**

Ethnicity – please tick box applicable to you

White	White British		**Mixed background**	White & black Caribbean	
	White Irish			White & black African	
	White other- please state			White & Asian	
Asian or Asian British				Other mixed – please state	
Asian or Asian British Chinese or other ethnic groups	Asian or British Asian - Indian		**Black**	Black Caribbean	
	Asian or British Asian - Pakistani			Black African	
	Asian or British Asian - Bangladeshi			Black British	
	Asian or British Asian – other Background – please state			Black – other background – please state	
Other ethnic group	Chinese				
PERSONAL MEDICAL HISTORY			**I do not wish to disclose my ethnicity**		

Please tick if the child suffers or has ever suffered from any of the conditions listed below

Asthma						Please detail any other serious or chronic illnesses, operations or disabilities
Cancer		**Diabetes**		**Heart trouble**		
Glaucoma		**Yellow Jaundice**		**High blood pressure**		
Any allergies?		**Tuberculosis**				

Allergies:	**No**		**Yes – please give details of your allergies below**

Is your child currently taking any drugs or medicines? If yes please list then below

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Have any close relatives, parents, brothers, sisters, ever suffered from any significant medical problems? Please give details below for example, Asthma, diabetes, High Blood Pressure, Stroke, Heart attack or Angina, Epilepsy, Migraine, Glaucoma, Cancer, Tuberculosis, Mental Health		
Relative		
	Problem	**At what age**
VACCINATION HISTORY		

1st DTP/POLIO					
1st HIB		2nd DTP/POLIO		3rd DTP/POLIO	
1st MenC		2nd HIB		3rd HIB	
Booster Hib		2nd MenC		3rd Men C	
MMR		MMR		Pre-school Booster	
		Other Vaccinations :			

Parent/Guardian/s name	**Mother**	**Father**	**Other**

You are also able to book appointments and view medical information online. Please tick the boxes to say what you would like access to.

If you wish to see your childs summary medical record online please read and agree with each statement (please tick a-e)		**Requesting medication**		**Access to you summary medical record online**	
A	I have read and understood the information leaflet provided by the practice				
B	I will be responsible for the security for the information that I see or download				
C	If I choose to share my information with anyone else, this is at my own risk				
D	I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement				
E	If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible Signature of patient				

Signed on behalf of child	Print name	Signature	Relationship to child

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For Reception Use Only

Patient NHS no		**Patient Emis. no**	
Identification verified by (Initials)	**Date**	**Method**	
		Couching	
		Vouching with information in record	
		Photo ID and proof of residence	

Type of document	**Driving licence**		**Passport**		**National id**		**Other**	
Document no								
Country of issue								

Clinical Use			
Signature of Authorising clinician		**Date**	

For Online Password Issuer only			
Date account created		**Level of access enabled**	
Date password issued		**Prospective**	
Retrospective		**All**	
Limited parts		**Contractual minimum**	

PPG information

PPG information given			
Patient interested; Contact information	**Patient contact number**	**Mobile**	**Landline**
Patient interested in online participation	**Patient Email address:**		